

World Vision Relief & Development, Inc.

WVRD/Dominican Republic **FY91**  
FINAL EVALUATION REPORT  
BARAEONA CHILD SURVIVAL PROJECT  
December 30, 1994

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Office of Private and Voluntary Cooperation  
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## List of Acronyms

AR1	Acute Respiratory Infections
BCG	Bacilli Calmette-Guerin (tuberculosis vaccine)
CDD	Control of Diarrheal Diseases
cs	Child Survival
DIP	Detailed Implementation Plan
DPT	Diphtheria, Pertussis, Tetanus Immunization
EPI	Expanded Program on Immunization
EOP	End Of Project
GORD	Government of Dominican Republic
HIS	Health Information System
HSA	Health Surveillance Assistant
IGA	Income-Generating Activity
KAP	Knowledge, Attitude, <b>Practice</b> (Survey)
MCH	Maternal and Child Health
MOH	Ministry of Health
NGO	Nongovernmental Organization
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PVO	Private Voluntary Organization
RDP	Barahona Rural Development Program
RDP	Regional Development Program
RHO	Regional Health Office(r)
sss	Sugar-Salt Solution
TA	Technical Assistance
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid Immunization
UNICEF	United Nations Children's Fund
<b>USAID</b>	United States Agency for International Development
VHC	Village Health Committee
WCBA	Women of Childbearing Age
WHO	World Health Organization
<b>WV/DR</b>	World Vision Dominican Republic
WVRD	World Vision Relief & Development, Inc.

I. PROJECT **ACCOMPLISHMENTS AND LESSONS LEARNED**

A. Project Accomplishments

The Child Survival Project of Barahona has been operating for 36 months. Of the total population of 10,220, the project has actually reached 2,044 families, 2,247 women of childbearing age (WCBA), and 2,188 children under five years. Of these, 286 are age 0-11 months and 296 are age 12-23 months; this accounts for 100 percent of the total potential beneficiary population.

The project staff includes a project manager for health, an area Child Survival manager, two area coordinators who train and supervise volunteer village health promoters (VHPs), a secretary, and an accountant. The health coordinators are nurses with an MCH background; the project manager is a nutritionist who previously headed the Nutrition Department in the Ministry of Health.

This project has accomplished much toward addressing the Child Survival objectives set out in its DIP. For example, while the 1993 PROMFAMILIA Survey of Demographics and Health in the Dominican Republic reported a national rate of 5% exclusive breast-feeding, the final survey found that 70% of children under 4 months of age in the WV project area were being exclusively breast-fed. Furthermore, the survey revealed that **78.5%** of mothers nursed their child at normal or more than normal levels when the child had episodes of diarrhea, an achievement very close to the objective of 80% presented in the project DIP.

**Since** there will be no extension/expansion funded under USAID after September 30, 1994, the continuation of its efforts will draw heavily upon the will and resources of the communities where it has been established.

A1. State *the objectives of the project as outlined in the Detailed Implementation Plan.*

The objectives for the Child Survival Project are:

**EPI:** Eighty-five percent of children age 12-23 months completely immunized before their first birthday.

**TT** coverage of at least 70 percent of pregnant women before delivery.

**ORT:** Reduction of 60 percent in infant mortality due to diarrheal dehydration; 70 percent of mothers know how to properly prepare ORS and use it when their children have diarrhea; at least 85 percent of mothers continue to breast-feed their child when the child has diarrhea.

**ARI:** Of mothers of children age 0-4 years, 95 percent know two or three signs of pneumonia and know where to take their children for treatment.

**Nutrition:** Reduce malnutrition ( $>2SD$ ) by 50 percent among children under five years old; 60 percent of mothers exclusively breastfeed for four months.

**Child Spacing:** Increase to 80 percent the number of couples using modern contraceptives.

**A2. State the accomplishments of the project related to each objective.**

The end-of-project target for the **Expanded Program of Immunization** was complete immunization coverage of 85 percent of children age 12-23 months before their first birthday. Of the 93 children in this age group, 84 percent studied during the Final KPC Survey had been immunized with BCG, DPT3, OPV3, and measles. The access to EPI, as measured by OPV1, was 89.0 percent; 97.8 percent had received BCG, 84.8 percent had DPT3, 86.8 percent had OPV3, and 85.8 percent had measles vaccine. Of the mothers with Prenatal Care cards, 93 percent had two or more tetanus toxoid injections.

The end-of-project target for the **Control of Diarrheal Diseases** was the reduction of 60 percent of infant mortality due to diarrheal dehydration. Although the evaluation team had no access to mortality statistics, none of the community leaders, mothers, or community volunteers of the five communities interviewed by the team during the field visit knew of a single death of a child less than two years old in the last 12 months. Eighty-nine percent (89.7 percent) of mothers knew how to properly prepare ORS and used it when their children had diarrhea, considerably higher than the DIP objective (70 percent).

Eighty-six percent of children with diarrhea were given the same or more fluids.

**ARI Accomplishments:** At the end of the project, 73 percent of the mothers knew that rapid breathing and agitation were indicators of danger of pneumonia, and only 42.9 percent knew collapse of chest (indrawing) as a danger sign. Although these figures are more than  $1\frac{1}{2}$  times higher than midterm evaluation (MTE) levels, they are below the 95 percent target. As a result, only 70 percent of mothers with dyspnoeic children sought the appropriate professional care.

**Nutrition:** At the end of the project, 210 (97.7 percent) of the 215 mothers studied in the KPC survey had breastfed their children at least once. During the survey, 84 of them (40 percent) were breastfeeding their children and had breastfed them within the first hour after birth. Nine additional mothers breastfed before the eighth hour. At the

time of the survey, 70 percent of children less than four months of age were breastfed exclusively.

**Child Spacing:** The project did not succeed in meeting the objective of 80 percent of couples using a modern method of contraception; the Final KPC Survey showed that only 50 percent of mothers who did not want another child in the next two years using a modern method.

**A3. Compare project accomplishments with objectives and explain the differences. Describe any circumstance which may have aided or hindered the project in meeting these objectives.**

The Child Survival Project of Barahona has been operational for 36 months and reached 100 percent of the total potential beneficiary population. Ninety-one percent of all children surveyed had an immunization record, and based on immunization records, access to EPI seems virtually universal. Of the children age 12-23 months, 84 percent have been fully immunized (above the end-of-project target). Ninety-eight percent of the children had BCG, but if measured by OPV1, only 89.0 percent of children have real access to the services. This difference is explained by the fact that most deliveries of the low-income population in the country take place in MOH hospitals, and BCG is given routinely to every newborn before discharge. This also explains why 93.4 percent of pregnant women have two or more doses of TT.

Equally impressive have been the behavior changes in management of diarrheal episodes in the project population. Mothers continue breastfeeding during the episode, increase fluid intake, and 89 percent know how to prepare ORS correctly.

Seventy-three percent of the mothers know the signs of pneumonia and where to take their children if necessary. These changes may explain why mothers and community leaders interviewed in the communities visited during the final evaluation said that no child had died this year.

Exclusive breastfeeding during the first four months has increased from 26 percent (midterm evaluation result) to 70 percent, and birth spacing increased from 26 percent to 54.4 percent in the same time interval. Both, however, are below the end-of-project target.

Health promoters have made their programmed home visits, often accompanied by the health coordinators. Vaccination days were carried out by the health promoters. Some promoters also participate as vaccinators in the MOH national vaccination campaigns.

The poor showing in the project in the area of family planning promotion may be due to the overambitious objective which

actually exceeded the percent of mothers who did not want another child within the next two years.

**A4. Describe unintended benefits or project activities.**

The infrastructure and community organization that resulted from the inputs of the CSP activities were very beneficial toward sustainability of the accomplishments of the project at least at the household level.

**A5. Attach a copy of the project's Final Evaluation Survey, and state the results for each relevant indicator (see Table 1). Please be sure the results include numerator and denominator of information, as well as percentages for each indicator (see Annex 1).**

See Appendix 1 for the copy of the Final Evaluation's KPC Survey.

The significant achievements and findings from the Final KPC Survey are:

- Of children age 12-23 months, 84.6 percent had immunization cards and were completely immunized. This is contrasted to 19.5 percent at baseline and 44 percent in the midterm evaluation. The information system shows a complete coverage rate of 97 percent, as contrasted to 41 percent completely immunized based on history only in the baseline, but this does not take the maintenance of the immunization card by mother into account.
- Of the women interviewed, 63 percent had immunization cards and received two doses of tetanus toxoid. This is contrasted to zero in the baseline and 24 percent in the midterm evaluation. The information system shows 52 percent of all women of childbearing age and 100 percent of pregnant women having completed two doses of tetanus toxoid.
- Of mothers of children experiencing diarrhea during the previous two weeks, 90 percent had treated it with ORT. This is compared to 51 percent in the baseline and 66 percent in the midterm evaluation.
- Of mothers who were breastfeeding children experiencing diarrhea during the previous two weeks, 88 percent continued to breastfeed during the diarrhea episode. There is no comparable statistic in the baseline, but it is comparable with the 80 percent of the midterm evaluation.
- Seventy-three percent of mothers were able to mention that "tired" respirations and retracted chest with respiration indicated the need for acute medical treatment. This is contrasted to 65 percent in the baseline and 17 percent in the midterm evaluation. The

midterm survey recommended that these two specific symptoms be listed in order for the answer to be counted positively. The baseline was designed with a variety of danger symptoms to choose from, of which any two allowed the answer to be counted positively; thus the numbers are not comparable.

- Of mothers currently breastfeeding children under four months of age, 71 percent were not giving anything else. This is contrasted with 13 percent collected in the baseline and 26 percent in the midterm evaluation. This statistic indicates significant progress for final evaluation.
- Based on the information system, 91 children of an estimated 870 less than 36 months old (10 percent) have suffered from moderate or severe malnutrition. Of these, 49 (54 percent) are now in the normal range.
- Of women not wanting more children in the next two years (49.9 percent of the total women surveyed), 75 percent were not using a modern family planning method. There is no comparable number in the baseline.
- The percent of women interviewed who were currently pregnant was 7.7.
- Of mothers of children with diarrhea in the last two weeks, 14 percent treated it with antibiotics or anti-diuretics. This is contrasted to 60 percent in the baseline and 29 percent in the midterm evaluation.
- Of the mothers surveyed, 20 percent were self-declared illiterates. This contrasts with 23 percent in the baseline.
- Of mothers surveyed, 17 percent indicated they had some income-generation activity. The national average of households headed by women is 40 percent; there is **no** reason to believe that the rate in the communities is much less than that.
- The diarrhea prevalence rate in the previous two weeks was 26 percent. This is comparable to the baseline and midterm evaluation rates.

#### B. Project Expenditures

**B1. Attach pipeline analysis of project expenditures.** The headquarters and country pipelines follow this section.

The budget expenditures during the years of funding complied with what was budgeted in the DIP. It is important to notice that in 1991, when the proposal was submitted, the exchange rate in the Dominican Republic was **DR\$9** to a U.S. dollar. At

the end of grant, September 30, 1994, the exchange rate went up to DR\$12.50 to the dollar. This increase allowed the project to cover the increase in the costs of items purchased by the project as well as to cover the inflation rate.

During the first year of the project's implementation, the project carried out all it had planned. During the second year, the expenditures were carried out as planned in the DIP for that year and resulted in an excess remaining of US\$16,000 due to the increase in exchange rate which was not taken up by a corresponding inflation rate. This money was used to support the health promoters and their income-generation activities.

The spending rate per year over the three years is as follows:

FY92 = \$43,383  
FY93 = \$52,047  
FY94 = \$65,517

**B2. Compare the budget contained in the approved DIP with the actual expenditures of the projects. Were some categories of expenditures much higher or lower than originally planned? Please explain.**

Analyzing the budget accounts by category, some accounts show overspending while others show underspending:

**Personal Accounts (EOP):** This category shows overspending due basically to a difference between the exchange rate and the inflation rate; by EOP, the latter was higher than expected. Another reason for this overspending was that money had to be paid to each discharged employee at the project end which, according to the law, is calculated based on the number of years of service in a particular company. This expense had not budgeted. The payment for the years of service was possible due to the increase of the exchange rate.

Other accounts which show overspending are **training and communications**, but as the amounts were minimal, they did not cause any problems during the implementation of the project.

**B.3 Were project finances properly handled?**

A very tight system of budget controls was observed involving all financial transactions. Records are complete, well organized, and up to date, with a full-time accountant dedicated to the project who carefully monitors expenditures against the budget. Financial supervision was rigorously provided by the field office finance division, the Latin America regional office, and headquarters. Project financial reports are reviewed in detail by WVRD before quarterly financial reports were submitted to A.I.D., Washington, D.C.

1994 COUNTRY PROJECT PIPELINE ANALYSIS - REPORT FORM A

**WVRD/HEADQUARTERS**

GRANT #PDC-0500-G-00-1065-00

Actual Expenditures to Date  
(10/\_01/\_91\_ to \_09/\_30/\_94)

Projected Expenditures Against  
Remaining Obligated Funds  
(\_10/\_01/\_94\_ to \_09/\_30/\_95)

Total Agreement Budget  
(Columns 1 & 2)  
(\_10/\_01/\_91\_ to \_09/30/95\_)

**COST ELEMENTS**

**I. PROCUREMENT**

A. Supplies

8. Equipment

C. Services/Consultants/Evaluation  
SUB-TOTAL I

**II. EVALUATION**

SUB-TOTAL II

**III. INDIRECT COSTS**

HQ/HO Overhead \_\_20(%)  
SUB-TOTAL III

**IV. OTHER PROGRAM COSTS**

A. Personnel

B. Travel/Per Diem

1. In-country

2. International

C. Other Direct Costs

(Utilities, Printing, Rent,  
maintenance, etc.)

SUB-TOTAL IV

**TOTAL**

AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
\$0	\$0	\$0	\$2,925	\$1,575	\$4,500	\$2,925	\$1,575	\$4,500
0	0	0	0	0	0	0	0	0
0	0	0	4,875	2,625	7,500	4,875	2,625	7,500
0	0	0	7,800	4,200	12,000	7,800	4,200	12,000
26	0	26	19,360	10,438	29,798	19,386	10,438	29,824
26	0	26	19,360	10,438	29,798	19,386	10,438	29,824
24,962	4,003	28,967	16,198	18,160	34,358	41,160	22,163	63,323
24,962	4,003	28,967	16,198	18,160	34,358	41,160	22,163	63,323
97,188	13,523	110,711	29,899	54,909	84,808	127,087	68,432	195,519
2,365	676	3,041	35,514	19,720	55,234	37,879	20,396	58,275
24,309	5,510	29,819	(12,609)	790	(11,819)	11,700	6,300	18,000
927	310	1,237	4,923	2,840	7,763	5,850	3,150	9,000
124,789	20,019	144,808	57,727	78,259	135,986	182,516	98,278	280,794
\$149,777	\$24,022	\$173,801	\$101,085	\$111,057	\$212,142	\$250,862	\$135,079	\$385,941

# 1994 COUNTRY PROJECT PIPELINE ANALYSIS - REPORT FORM A

PVO/COUNTRY PROJECT: **WORLD VISION RELIEF AND DEVELOPMENT/  
DOMINICAN REPUBLIC CHILD SURVIVAL PROJECT**

Actual Expenditures to Date  
(09/30/91 to 09/30/94)

Projected Expenditures Against  
Remaining Obligated Funds  
--End of Grant--

Total D.I.P. Budget  
(Columns 1 & 2)  
(09/30/91 to 09/30/94)

## COST ELEMENTS

### I. PROCUREMENT

A. Supplies

B. Equipment

C. Services/Consultants

SUB-TOTAL I

### II. EVALUATION

SUB-TOTAL II

### III. INDIRECT COSTS

HQ/HO Overhead \_\_20(%)

SUB-TOTAL III

### IV. OTHER PROGRAM COSTS

A. Personnel

B. Travel/Per Diem

C. Other Direct Costs

(Utilities, Printing, Rent,  
maintenance, etc.)

SUB-TOTAL IV

TOTAL

AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
\$8,736	\$0	\$8,736	\$469	\$22,000	\$22,469	\$9,205	\$22,000	\$31,205
0	46,577	46,577	3,065	7,073	10,138	3,065	53,650	56,715
2,294	0	2,294	11,300	0	11,300	13,594	0	13,594
11,030	46,577	57,607	14,834	29,073	43,907	25,864	75,650	101,514
22,369	0	22,369	1,507	0	1,507	23,876	0	23,876
22,369	0	22,369	1,507	0	1,507	23,876	-	23,876
31,017	82,368	113,305	2,183	56,680	58,863	33,200	139,048	172,248
31,017	82,368	113,385	2,183	56,680	58,863	33,200	139,048	172,248
93,738	0	93,738	(16,165)	0	(16,165)	77,573	0	77,573
0,077	0	8,077	5,453	0	5,453	13,530	0	13,530
25,733	11,529	37,262	2,489	(11,529)	(9,040)	28,222	0	28,222
127,548	11,529	139,077	(8,223)	(11,529)	(19,752)	119,325	0	119,325
\$191,964	\$140,474	\$332,438	\$10,301	\$74,224	\$84,525	\$202,265	\$214,698	\$416,963

II. **PROJECT SUSTAINABILITY**

A. Community Participation

Al. ***Please identify community leaders and members interviewed and indicate which group(s) the leaders represent.***

The evaluation took place in the Dominican Republic September 12-23, 1994. The first day was spent in Santo Domingo meeting with management staff from World Vision and the Dominican Republic and Dr. Amiro Perez Mera, consultant team leader. The team then traveled to the town of Barahona, which became the focal site for the remainder of the evaluation. Of the four days spent in Barahona, two were spent meeting with staff and the Ministry of Health; two were spent visiting villages in Barahona, and the last day was spent discussing and reviewing the results.

The community leaders interviewed were:

***Ministry of Health:***

Dr. Manolo Feliz—Regional Health Manager  
Dr. Victor Ventura—Regional Epidemiology  
Lit. Gladys Pacheco—Maternal Health Nurse

***Catholic Church (Bahoruco, Barahona Community):***

Manolo Resumil—Catholic Leader

***Community Leaders:***

***Jaquimeyes:***

Virgilio Beltre—Jaquimeyes, Mayor  
Altagracia Matos—Health Committee Coordinator  
Juana Matos—Mother

***Fundacion:***

Milod Antonio Matos—Community Leader  
Julina Garcia—Accountant Partnership Project (WV/DR)  
Delia Suer—Public Health Nurse  
Aura Suero—Health Promoter

***Hato Viejo:***

Roberto Garcia—Accountant Partnership Project (WV/DR)  
Rudecinda Garcia—Mother

***Fudeco:***

Florentina Feliz—Health Promoter  
Esmirna Aria—Samuel Project Manager  
Rosa Feliz—Mother

***Juan Estevan:***

Bernardo Aquino—Pastor  
Elba Aquino—Health Promoter

- A2. ***Which child survival activities do community members and leaders perceive as meeting current health needs?***

They value immunizations, oral rehydration therapy, pneumonia treatment, and home visits by health promoters.

- A3. ***What activities did WVRD carry out to enable the communities to better meet their basic health needs and increase their ability to sustain effective child survival project activities?***

The World Vision/Dominican Republic-Barahona Child Survival Project was an expansion of the existing World Vision development project. WVRD health staff provided training to development facilitators and to the development committees. From the beginning, the project was integrated into the existing community development activities. Development committees organized the Child Survival committees and recruited the community volunteers. WVRD health staff trained the committees and volunteers and linked these community organizations to MOH services at regional and local levels.

The project assisted the communities in the organization of a community-based essential drug supply system and a basic sanitation program to improve safe water supply and sanitation. Also, it provided for the expansion of EPI coverage to the communities.

- A4. ***How did communities participate in the design, implementation, and/or evaluation of child survival activities?***

WVRD staff has trained participating community leaders in design, planning, and evaluation since the beginning. Health committees have been involved in each step of the phasing in of the project activities.

- A5. ***What is the number of functioning health committees in the project area? How often has each met during the past six months? Please comment on whether committee members seem representative of their communities.***

There are 15 committees, one for each community, appointed by the community development organizations. They meet regularly each week. Their members, all leaders of community organizations, represent the majority of the population.

- A6. ***What are the most significant issues currently being addressed by these health committees?***

The most important issues are (1) to increase coverage with the package of Child Survival interventions and (2) to continue the administrative support of the essential drug supply to the communities.

- A7. Please give specific examples of the methods used by these health committees and of their precise role in providing direction to the project.**

The development committees continue to be strong in 10 of the 15 communities, and two others are doing moderately well. Only three of the communities have minimally functioning committees that require much support. In the stronger communities, they are independently running the drug supply systems, monitoring the health promoters, and providing money for the collection of vaccines from the MOH.

- A8. What resources has the community contributed that will encourage continuation of project activities after donor funding ends?**

Local participating organizations are aware of the importance of CS activities, and they now know how to apply them in their communities. More specifically, they know where and how they can tap into services and resources as well as sources of available external support. Three of the communities studied by the evaluation team considered the project as their own and clearly expressed that the project will be sustained even after the external support terminates.

- A9. What are the reasons for the success or failure of the committees to contribute resources for continuation of effective project activities?**

The WVRD Barahona/Child Survival Project was located in some of the poorest areas of the country. This specific health project is only one component of a broader development project. Community organization, community involvement, and income-generation activities improved the quality of life in these communities and provided them needed expertise to solve some of the sustainability problems. Most of the communities are aware of the existence of locally or regionally available resources that they can now use. Even the less advanced communities (those with lower economic levels) are progressing slowly but steadily.

- B. Ability and Willingness of Counterpart Institutions to sustain Activities**

- B1. Please identify persons interviewed and indicate their organization and relationship to the child survival project.**

Dra. Mildred Acosta, Manager, National Acute Respiratory Infection; Dra. Sonia Valdez, Supervisor, National Expanded Program of Immunization, Ministry of Health.

They regularly support the training activities of the Child Survival project training.

- B2. What linkages exist between the child survival project and the activities of key health development agencies?**

The MOH, W/DR, and other PVOs involved in Child Survival activities regularly collaborate at national, regional, and local levels. Previously underused resources are now effectively available to those in need of them.

- B.3 What are the key local institutions WV/DR expects to take part in sustaining project activities?**

W/DR expects to continue to work with the development committees and community organizations.

- B4. Which child survival project activities do MOH personnel and other staff in key local institutions (including counterpart organizations) perceive as being effective?**

The principle counterpart organization in the Child Survival Project has been the Ministry of Health (MOH). Together with the W/DR Child Survival staff, there has been extensive training exchanged across programs, some collaborative supervision of committees and promoters' performance at the village level occurs, and joint planning discussions take place regularly.

- B5. What did WVRD do to build skills of local MOH personnel or staff of key counterpart NGOs? Did they teach them to train CHWs or manage child survival activities once USAID funding ends?**

Extensive training, both in Child Survival technologies and management aspects, are the most relevant contribution of the project.

- B6. What is the current ability of MOH or other relevant local institutions to provide the necessary financial, human, and material resources to sustain effective project activities once CS funding ends?**

MOH provided vaccines, staff, and other material resources for CS project activities in addition to technical support and training. This support can be expected to continue.

- B7. Are there any project activities that counterpart organizations perceive as effective?**

Ministry of Health perceives the community-based infrastructure and community organization as effective. Also, it recognizes the effectiveness of the immunization activities.

- B8. How have major project responsibilities and control been phased over to local institutions? If this has not been done, what are the plan and schedule?**

Local institutions already have assumed major responsibilities of the project. It is reasonable to consider that local organizations are ready for continuing support of these new health interventions.

- B9. Did any counterpart institutions (MOH, development agencies, local NWS, etc.) during the design of the project (proposal or DIP) make a financial commitment to sustain project benefits? If so, have these commitments been kept?**

The MOH made the commitment to sustain CS activities at the outset and have kept it.

- B10. What are the reasons given for the success or failure of the counterpart institutions to keep their commitment?**

Communities have been actively involved in the CS activities and have ensured that the MOH support will be sustained after the project ends.

- B11. Identify in-country agencies which worked with WVRD on the design, implementation, or analysis of the midterm evaluation and this final evaluation.**

Mr. Manolo Feliz, the Regional Ministry of Health Manager; Dr. Victor Ventura, epidemiologist, the Regional Ministry of Health; and Mr. Hector Rodrigues, Human Resources statistician with the MOH all have worked with W/DR on design, implementation, and analysis of the MTE and this Final Evaluation.

- c. Attempts to Increase Efficiency**

- c1. What strategies did WVRD implement to reduce costs, increase productivity, or otherwise make the project efficient?**

The W/DR CS project reduced the training costs of field personnel and community volunteers through URC and the purchasing of scales through CONASUMI. Also, community involvement through the use of low opportunity cost personnel time was probably the most important contribution to cost reduction.

- c2. What are the reasons for success or failure of the attempts to increase efficiency of this project?**

The integration of this CS project into the context of ongoing development project work that had been already established was the key element to success.

- c3. Are there any lessons to be learned regarding attempts to increase efficiency that might be applicable to other PVO child survival projects or to USAID's support of these projects?**

Strong and sustained community support and involvement are most important in efforts to improve efficiency.

D. Cost Recovery Attempts

- D1. What specific cost recovery mechanisms (i.e., revenue-generating measures) did WRD implement to offset project expenditures? If cost recovery was part of the project, who managed implementation?**

Cost recovery efforts were implemented by the W/DR Barahona Development Project; unfortunately, data are not desegregated for the W/DR CS project specifically.

- D2. Estimate the dollar amount of costs recovered during the project. What percent of project costs did this revenue cover? Did the cost recovery mechanisms generate enough money to justify the effort and funds required to implement the mechanisms?**

No information available.

- D3. What effect did any cost recovery activity have on the reputation in the community? Did the cost recovery venture result in any inequities in service delivery?**

No information available.

- D4. What are the reasons for the success or failure of the household income-generating activities of this project?**

No information available.

E. Household Income Generation

- E1. Did the project implement any household income-generating activities?**

Income-generation activity was an important aspect of the W/DR Barahona Development Project but was not included in the CS project.

- E2. Estimate the dollar amount of income added to a family or household's annual income, as a result of the income-generating activity of the project.**

N/A

- E3. Did the revenues contribute to meeting the cost of health activities? What percentage of project costs did income generation cover?**

N/A

**E4. Are there any lessons to be learned regarding household income generation that might be applicable to other PVO child survival projects or to USAID's support strategy?**

N/A

**III. EVALUATION TEAM**

**A1. Identify by names, titles, and institutional affiliations all the members of the final evaluation team.**

The members of the evaluation team include:

- Dr. Jose Angel Giron, MPH, External Consultant, WV/ORALYC (World Vision Lacro Regional Office)
- Dr. Amiro Perez Mera, MPH, Internal Consultant
- Dr. Lawrence Casazza, MPH, WRD/Washington, D.C.
- Santiago Rodriguez, BS, Director of Operations, World Vision, Dominican Republic
- Carmen Lucia Graveley, BS/Nutrition/Project Manager

The actual involvement of the various members varied from one day's input to entire course of the Evaluation process. Dr. Casazza had one day to brief the experienced members of the team on the USAID Guidelines for the Final Evaluation; Dr. Giron participated in the actual field work together with Carmen Graveley and Dr. Amiro Perez Mera. The latter two did the writing of the report with input from Mr. Santiago Rodriguez for financial information.

**A2. Identify the author of the evaluation report.**

The author of this report is Dr. Amiro Perez Mera, MPH.

**APPENDIX**  
Program of Evaluation Activities  
September 12-23, 1994

**September 11:** Arrival of Dr. Jose Giron

**September 12:**

8:30 a.m. Meeting with Dr. Amiro Perez-Mera, Dominican Consultant, and Dr. Jose Angel Giron, External Consultant.

10:30 Meeting with Cesar Lopez, World Vision Field Office Director

11:30 Meeting with Claudio Done, Field Office Finance Director

2:30 p.m. Meeting with Santiago Rodriguez, Director of Operations

**September 13:**

7:00 a.m. Travel to Barahona

11:00 Meeting with Field Health Team

2:30 p.m. Visit with Development Committee, health promoters, and mothers in Jaquimeyes and La Hoya

**September 14:**

8:30 a.m. Meeting with Dr. Manolo Feliz and Dr. Victor Ventura from Regional Ministry of Public Health

10:30 Visit with leaders and mothers in Fundacion Community

2:30 p.m. Visit with leaders and mothers in Batoruco Community

**September 15:**

8:30 a.m. Meeting with evaluation team to review results and recommendations

2:30 p.m. Return to Santo Domingo

**September 16:**

8:30 a.m. Meeting with management staff from Santo Domingo to review results and recommendations

2:30 p.m. Work on writing report

TABLE 1

No.	Indicator (Submit results only for indicators that reflect project interventions)	Results Numerator (N) Denominator (D) Percent (P)
01	<b>NUT: Initiation of Breastfeeding</b> -Percent of infants/children (less than 24 months old) who were breastfed within the first eight hours after birth.	N = 193 P = 89 D = 215
02	<b>NUT: Exclusive Breastfeeding</b> -Percent of infants under four months who are being given only breast milk.	N = 24 P = 70.6 D = 34
03	<b>NUT: Introduction of Foods</b> -Percent of infants age 5-9 months who are being given solid or semi-solid foods.	N = 33 P = 80.5
04	<b>NUT: Persistence of Breastfeeding</b> -Percent of children 20-24 months old who are still breastfeeding (and being given solid/semi-solid foods).	N = 0 P = 0 D = 16
05	<b>CCD: Continued Breastfeeding</b> -Percent of infants/children (less than 24 months old) with diarrhea in the past two weeks who were given the same amount or more food.	N = 30 P = 60 D = 50
06	<b>CCD: Continued Fluids</b> -Percent of infants/children (less than 24 months old) with diarrhea in the past two weeks who were given the same amount or more food.	N = 38 P = 86 D = 46
07	<b>CCD: Continued Foods</b> -Percent of infants/children (less than 24 months old) with diarrhea in the past two weeks who were given the same amount of food or more.	N = 27 P = 76 D = 50
08	<b>CCD: ORT Usage</b> -Percent of infants/children (less than 24 months old) with diarrhea in the past two weeks who were treated with ORT.	N = 33 P = 66 D = 50
09	<b>Pneumonia Control: Medical Treatment</b> -Percent of mothers who sought medical treatment for infant/child (less than 24 months old) with cough and rapid, difficult breathing in the past two weeks.	N = 28 P = 70 D = 40
10	<b>EPI: Access</b> -Percent of children age 12-23 months who received <b>DPT1</b> .	N = 77 P = 95.3 D = 81
11	<b>EPI: Coverage</b> -Percent of children age 12-23 months who received <b>OPV3</b> .	N = 73 P = 90 D = 81
12	<b>EPI: Measles Coverage</b> -Percent of children age 12-23 months who receive Measles vaccine.	N = 68 P = 83.9 D = 81
13	<b>EPI: Drop-Out Rate</b> -Percent of change between DPT1 and DPT3 doses [(DPT1-DPT3)/DPT1] for children age 12-23 months.	N = 3 P = 4.1 D = 74

No.	Indicator (Submit results <b>only</b> for indicators that reflect project interventions)	Results Numerator (N) Denominator (D) Percent (P)
14	MC: Maternal Card-Percent of mothers with a maternal card.	N = 105 P = 48.8 D = 215
15	MC: Tetanus Toxoid Coverage (Card)-Percent of mothers who received two doses of tetanus toxoid vaccine (card).	N = 99 P = 94.3 D = 105
16	MC: Antenatal Visits (Card)-Percent of mothers who had at least one antenatal visit prior to the birth of the child (card).	N = 105 P = 100 D = 105
17	MC: Modern Contraceptive Usage-Percent of mothers who desire no more children in the next two years, or are not sure, who are using a modern contraceptive method.	N = 80 P = 54.4 D = 147

BARAHONA CHILD SURVIVAL PROJECT FINAL REPORT

APPENDIX 1

**WVRD/Dominican** Republic FY 91

KNOWLEDGE PRACTICE COVERAGE  
FINAL SURVEY  
BARAHONA CHILD SURVIVAL PROJECT  
BARAHONA, DOMINICAN REPUBLIC

August 1994

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#### **ACKNOWLEDGEMENTS**

We would like to thank all the people who made this knowledge and practice survey in health possible, and especially the families in the communities who showed us hospitality and answered our questions courteously. Thanks to the team of interviewers and supervisors for their professionalism in collecting and analyzing the information; to Amiro Perz Mera, external Consultant, and to Jose Angel Giron, Regional Office Adviser, who with their knowledge and skills helped the CSP team to complete this survey.

## I. INTRODUCTION

### A. Background

The Child Survival Project is located in Barahona, in the southwest of the country, 200 kilometers from Santo Domingo, the capital of the Dominican Republic. The interventions are being implemented in 15 rural communities which were selected according to the following criteria:

- Belong to Health Region IV, one of the three areas declared by the MOH as priority areas.
- Have strong superstitious beliefs concerning children's and pregnant women's health.
- Women start their reproductive period at an early age, resulting in a high percentage of young single mothers with two or more children.
- World Vision is implementing a Development Project with which the Child Survival Project's interventions combine to form integrated projects.

In these communities, as in most of the rural communities of the country, the two main causes of infant morbidity and mortality are diarrhea and acute respiratory infections (ARI). together with those risk which enable malnutrition particularly those related to the premature weaning, environmental hygiene, inadequate water within the house, and poor human waste and garbage disposal which make evident and relate the child with diseases such as gastroenteritis.

We know that the development of a program to improve the health of the population requires a knowledge of the prevailing conditions and context in the area where it is implemented. This will allow for monitoring of the intervention process and improving the effect of the interventions being implemented. That is why this project's midterm evaluation is so important; it will identify areas of strength and weakness, and based on these findings, allow project staff to formulate strategies for the second half of the project's implementation.

### B. Objectives of the Survey

The final survey, together with financial analysis and a formal assessment by an external evaluation team based on USAID guidelines together comprised the final evaluation of the Barahona CSP. Several objectives were set for the survey, including:

1. To provide quantitative information on the progress that the project has made since its inception toward reaching its stated objectives.
2. To identify areas of strength and weakness and, based on these findings, to assist project staff to formulate effective strategies for the second half of project implementation.

3. To train project and MOH staff on the methodology and implementation of 30 cluster sample survey techniques.

In terms of the project's main interventions, the survey was designed to provide information specifically on the following issues of interest to the main project interventions:

- Knowledge and practices of mothers of children under two regarding breast-feeding, nutrition, immunization, prenatal care, management of diarrheal diseases and acute respiratory infections, and family planning/child spacing.
- Appropriate target groups for health education.
- Access to immunization services, coverage rates of BCG, DPT, polio, measles, and TT vaccines, and for children 12-23 months of age, the fully immunized rate.
- ORT use rate.
- Contraceptive use rate.

Questionnaires were addressed at mothers of children under two years (0 - 24 months) of age. Although many project activities target a group more broad than this, all interventions include under twos as a primary target group. Some activities, especially promotion of appropriate breast-feeding and weaning practices, are intended specifically for the benefit of this group and so are targeted at their mothers or other primary caretakers. Restricting the sample to these mothers also makes it possible to measure the extent to which the project has been able to reach those children born during the life of the project.

### C. Schedule of Activities

Preparations for the Final survey began in July 1994, with a review of the questionnaire used during the Mid-Term survey, selection of interviewers, and making logistical arrangements. Final preparations, training, interviewing, data analysis, and report writing occurred as follows:

- |        |        |  |
|--------|--------|--|
| August | 9-10:  | Continuation of preparations, finalization of logistical arrangements. |
| August | 17-18: | Training of supervisors.   |
| August | 19-20: | Training of interviewers.  |
| August | 22:    | Field test of questionnaire.   |
|        | 23:    | Review of field test.  |
|        | 24:    | Finalization of questionnaires.  |
| August | 25-26: | Household interviews.  |
| August | 29:    | Epi Info training and preparation of software for data entry.          |

August 30: Input of data into Epi Info and data analysis.  
Beginning of report writing.

August 31: Discussion of results with supervisors and coordinators.  
Report writing.

## II. **METHODOLOGY**

### A. The Questionnaire

The questionnaire used during the baseline survey in February 1992 was adapted from the generic "PVO Child Survival Knowledge and Practice Questionnaire" developed for use in USAID Child Survival Projects by The Johns Hopkins University Child Survival Support Program (JHU CSSP) and other U.S. and international experts. Based on updates in this generic questionnaire, additional information needs, and changes in the project since the original survey, the baseline questionnaire was modified somewhat for use in the midterm survey.

The majority of questions appeared on both surveys, but in some cases the Spanish was somewhat different, since at midterm a Spanish translation of the generic questionnaire made available by JHU CSSP was used as a basis. A few questions used in the baseline survey were dropped from the midterm questionnaire, and seven new questions were added (numbers 6, 8, 10i, 11, 21, 22, and 41).

During the training of supervisors and interviewers and after field-testing the questionnaire, some minor additional modifications were made. In its final version, the questionnaire contained 41 questions:

Questions 1-2:	Age of mother and child
Questions 3-6:	Mother's education, occupation, and health concerns
Questions 7-11:	Breast-feeding and nutrition
Questions 12-22:	Diarrheal diseases and their management
Questions 23-27:	Treatment of acute respiratory infections
Questions 28-33:	Immunization
Questions 34-36:	Maternal care
Questions 37-41:	Family planning and prenatal care

Appendices A contains the Spanish versions of the final questionnaire.

### B. Determination of Sample Size

In accordance with the World Health Organization (WHO)/Expanded Program on Immunization (EPI) 30 cluster methodology (see Lemeshow and Stroh, 1988, and Bennett, et al., 1991), to determine the size of the sample to be selected, the following formula was used:

$n = (z) (z) pq / (d) (d)$  where  $n$  = sample size  
 $z$  = statistical certainty desired  
 $p$  = estimated prevalence, coverage rate,

or level of knowledge  
 $q = 1-p$  (the proportion without the  
attribute of interest)  
 $d$  = precision desired

In accordance with the WHO/EPI methodology, the desired precision ( $d$ ) was set at .10 and statistical certainty at 95 percent ( $z = 1.96$ ). The value of  $p$  was set at .5, the value which requires the maximum sample size. The resulting sample size,  $n$ , was 96. This is the size of the sample to be chosen if a simple random sample is selected and it is desired that the population estimate obtained from this sample be within 10 percent of the true value in the population 95 percent of the time (given repeated samples and an unbiased sample selection).

To compensate for the effect of choosing a sample of people in clusters rather than as randomly selected individuals, it is necessary to approximately double the sample size (see Henderson and Sundaresan, 1982). A total of 215 mothers were therefore interviewed.

### C. Selection of the Sample

Since the project is currently focusing its efforts on only 15 communities, which are not easily or meaningfully divided further, strict adherence to the WHO/EPI methodology was not possible.

At baseline, two clusters of seven households each were surveyed in each of the 15 clusters, regardless of size. Given considerable variation in the sizes of the communities (ranging from approximately 300 to 2,500 in total population; see Appendix C), it was felt that this procedure over-represented the smaller communities, in addition to making it difficult to find the required number of interviews in such places. To address these concerns, the number of interviews conducted in each community was made proportionate to the size of the community.

Once the number of interviews in each community was determined, these were divided into clusters, such that no cluster contained more than seven interviews, in order to ensure the desired degree of precision. In all, 35 clusters, each with a different randomly selected starting point, were sampled. The selection of the starting household was simplified by the fact that detailed maps of each of the 15 project communities, showing all households, had recently been drawn by health promoters assigned to the respective communities. All households were assigned a number and one was randomly selected. Communities where more than one cluster was to be selected were divided into approximately equal segments, and the appropriate number of starting households were then randomly selected, one from each segment.

Interviewers were brought by a supervisor to the randomly selected starting houses. If the house contained a mother of a child under two years, she was included in the sample and was interviewed; otherwise, the interviewers proceeded to the next house. Additional households were chosen by finding the next nearest household (the one whose front door was closest to the house in question), staying within the boundaries of the cluster as drawn on

the map. If there was uncertainty regarding which house was closest, interviewers were trained to choose randomly between or among them.

In instances where a household contained more than one mother with a child under two, only one of them was randomly selected for interview. If one mother had more than one child under two years, the mother was interviewed regarding the youngest, about whom it was assumed she would have the best recollection and accuracy of information. A significant proportion of mothers in the project area have left their communities for extended periods of time to work in the capital or in Europe. In such cases, the primary caretaker of the child, usually a grandmother, was interviewed; questions which could not be answered were left blank.

#### D. Training of Supervisors and Interviewers

A total of five supervisors and 16 interviewers were selected for training and participation in the actual survey. The first day of training was attended by all supervisors, including the WVDR national coordinator, Carmen Graveley, the area coordinator, Nertha Castro, the two area supervisors, Andrea Gomez and Adela Vargas, and an intern placed by WVRD headquarters. The training was conducted by Dr. Amiro Perz Mera, external Consultant. The purpose and objectives of the survey, the methodology to be used, responsibilities of supervisors, and a thorough review of the questionnaire, including the purpose of each question and proper coding of respondent's answers, were the focus of the training.

Training of interviewers on the following day was facilitated by the five supervisors and covered the same topics as those covered during the training of supervisors, with increased emphasis on the questionnaire and a discussion on proper **conduct of interviews**. Several role-plays were conducted and discussed.

On the third day, a field test of the questionnaire was conducted in a community in Barahona province not included in the project area. The selection procedure for additional households was practiced in the field, and all interviewers identified and interviewed a minimum of two mothers with a child under two years. Supervisors observed interviewers, reviewed the completed questionnaires, and provided individual feedback to each interviewer.

Following completion of the field test, the survey team met as a group to review the experiences of the field test, discuss problems encountered, review errors made in completing the questionnaire form, and make minor revisions in the questionnaire.

#### E. Conduct of the Interviews

Each supervisor was assigned three interviewers. Supervisors were responsible for randomly selecting a starting household and for supervising the selection procedure for additional houses. They observed at least one interview conducted by each of their three interviewers on each of the two days of interviewing. Each questionnaire was checked by supervisors and the survey trainer for accuracy and completeness prior to departing from the community so

that in cases of inaccuracies or missing information, the household in question could be visited again.

All interviews were conducted in Spanish.

#### F. Method for Data Analysis

WVDR field office and project staff decided to tabulate and analyze the data on the computer rather than manually. The survey trainer trained the project coordinators on the use of Epi Info and together entered the data from all questionnaires. Frequency distributions for each variable were produced and cross-tabulations of selected variables of interest were made.

### III. RESULTS

Following are the responses obtained from the 215 eligible mothers included in the sample.

#### A. Age Distribution

1. The average age of the mothers surveyed was 25 years. Of the 215 mothers who knew their age, 30 (14 percent) were less than 20 years old and 45 (21 percent) were more than 30 years old.
2. The average age of the children in the survey was 10 months. A total of 122 children (56 percent) were less than 12 months old, and 93 (43 percent) were between 12 and 23 months old.

#### B. Mother's Education and Income-Generating Activities

3. Of the 215 mothers surveyed, 22 (10 percent) reported not having any formal education. The illiteracy rate determined was 43 (20 percent). Of 124 mothers had completed any grade of primary education, but 23 of these (11 percent) did not know how to read. Seventy-one mothers (33 percent) had gone to secondary school.
4. When the mothers were asked if they were practicing any income-generating activity, 189 (89 percent) answered negatively and 24 (11.2 percent) answered positively. Of these 24 mothers, 2 work as maids, 5 work at stores, and 3 reported practicing other income-generating activities.
5. Thirty seven of the mothers (17.4 percent) said that they took their children to their work places. 98 (46.5 percent) leave their children with grandmothers, thirty-seven (17.4 percent) with a brother or sister, 25 (11.7 percent) with the husbands, and 15 (7.0 percent) with neighbors. Only two mother (1 percent) leaves her child alone when she needs to go out.

#### C. Most Common Household Diseases

6. When the mothers were asked what the most common household diseases were, 171 (79.5 percent) answered acute respiratory infection, 20 (29.3 percent) fever/convulsions, 16 (7.4 percent) vomit/diarrhea, 2 rheumatism, and 4 answered others.

D. Breast-Feeding and Nutrition

7. Of the 215 mothers surveyed, 110 (51.2 percent) were still breast-feeding their child during the survey, while 100 (46.5 percent) were not.
8. Of the 105 mothers who were not breast-feeding their child, 100 (95.2 percent) had breast-fed the child before and 5 (2.3 percent) had never breast-fed their child. A total of 210 of the mothers (97.6 percent), then, had breast-fed their children at least once after having given birth.
9. When the 210 (97.6 percent) mothers who answered that they had breast-fed their child at least once were asked when they had breast-fed their child for the first time, 184 (88.5 percent) answered that they had breast-fed for the first time during the first hour after having given birth and 9 (4.3 percent) during the first 8 hours. Fourteen mother (6.7 percent) waited more than 8 hours. One mother did not know when she breast-fed her child for the first time.
10. Cross-tabulating the ages of the children surveyed and the food and liquids (not including breast milk consumed), it was determined that 24 of the 34 children under 4 months of age (70.6 percent) were being breast-fed exclusively. Of the 102 children older than 4 months, 93 (91 percent) were receiving sources of Vitamin C, 98 (96 percent) were receiving sources of Vitamin A, 102 (100 percent) were receiving sources of protein, and 102 (100 percent) were receiving food with high-energy content.

Food Consumption by Source of Nutrient

Nutrient	Number	Percentage	Source
Vitamin C	93	94	Fruit, orange, cherry, grapefruit, pineapple, and/or guava
Vitamin A	98	99	Carrot, mango, papaya, squash, lettuce, carrot leaf, and/or molondron (DGLVs)
Protein	102	100	Meat, fish, eggs, cheese, and/or beans
Energy	102	100	Sugar, honey, oil, and/or butter

E. Diarrheal Diseases

11. Of the 215 mothers, 53 (24.8 percent) indicated that their child had had a diarrhea episode during the last two weeks before the survey.

- 53-12 212 72-2420
12. Of the 15 mothers who indicated that their child had had an episode of diarrhea in the specified time period, 12 had already stopped breast-feeding the child. Of the remaining mothers, 7 (14 percent) breast-fed more frequently, 7 (14. percent) continued to breast-feed their child as normal, 4 mothers (7.5 percent) breast-fed less than usual, and 5 quit breast-feeding due to the diarrhea.
  13. One of the 53 children who had had diarrhea had not been receiving other liquids besides breast milk; Of the 49 children who were receiving other liquids, 20 (40. percent) received the same amount of liquids they were used to receiving. Eight (13.8 percent) children received fewer liquids than usual during the episode of diarrhea.
  14. Three of the children with diarrhea had not been given any solid or semisolid food before the episode of diarrhea. Of the 47 remaining children, 9 (18.0 percent) received the same amount of food. Ten (20 percent) children received less food than usual, and 10 (20.7 percent) children were not fed due to the diarrhea.
  15. Of the 53 mothers who reported their child having diarrhea, 33 (66 percent) used some form of oral rehydration therapy, including oral rehydration packets, home-prepared solutions, rice water, and juices. In order to rehydrate the children having diarrhea, 24 mothers (48 percent) used oral rehydration salt packs, 9 (18 percent) used home-prepared solutions, 3 (5.2 percent) used rice water, and 15 (25.9 percent) used fruit juices. Seven mothers (14 percent) gave their child antidiarrheal medicine or antibiotics during the diarrhea. 8 mothers did not use any treatment during the diarrhea.
  16. Of the 53 mothers whose child had had diarrhea, 29 (58. percent) sought advice or treatment, and 21 (42 percent) did not.
  17. Of the 34 mothers who sought advice or treatment during their child's diarrhea, 10 (29 percent) went to relatives for help, 6 (17.6 percent) went to the hospital, 10 (29 percent) went to the health center, 25 (73 percent) went to a health promoter, and 8 (23 percent) went to a private doctor or to a clinic. None of the mothers reported having gone to a pharmacy, midwife, or traditional healer.
  18. All the mothers were asked what symptoms would cause them to seek help in treating their children's diarrhea. The frequency of answers was as follows: Thirst, dry mouth, sunken eyes, sunken cranium, little urine (signs of dehydration) (49.8 percent), weakness or lack of appetite (32.1 percent), prolonged diarrhea (31.2 percent), fever (18.1 percent), loss of appetite (10.1 percent), vomit (13 percent), blood in the feces (5.6 percent), and do not know (12.5 percent).
  19. The 215 mothers were asked what actions they should take when their child is sick with diarrhea. Six mothers (2.8 percent) answered that they did not know what to do if their child had

diarrhea. Of the rest of the mothers, **102 (47.4 percent)** answered that they would give the child more liquid, 21 (9.8 percent) stated they would give food more frequently, 121 (56.2 percent) answered they would prepare and give their child ORS, 34 (15.8 percent) answered they would take the child to a health center, and 6 (2.8 percent) stated they would give the child more food after the diarrhea so that he/she could regain the lost weight. Three mothers (0.9 percent) stated they would stop feeding the child. Eighteen (8.4 percent) gave other answers.

20. One hundred ninety-two mothers (89.7 percent) correctly quoted the recipe for preparing the oral rehydration salt packets.
21. When the 215 mothers were asked what they should do when their child was recovering from diarrhea, 83 (40 percent) answered they should give the child more food than usual and 19 (9.1 percent) answered they should give the child food containing a lot of calories. Thirty-three mothers stated they did not know what to do. Twenty-eight gave other answers.

#### F. Acute Respiratory Infections

22. Of the 215 mothers surveyed, 103 (48.7 percent) reported their child had been sick with cough or difficult breathing during the last two weeks prior to the survey. Eighty-eight (**31.7 percent**) reported their children did **not have these** symptoms.
23. Of the **108** mothers who reported that their child had been sick with cough or difficult breathing, 68 (62.5 percent) answered that their child had also experienced rapid and difficult breathing. (**Dyspnea**)
24. Of the 68 mothers whose children had rapid breathing or dyspnea, 40 (59 percent) sought help for the care of the child and 22 (32 percent) did not seek help.
25. Of the 40 mothers who sought help for the illness of their child, 13 (32.3 percent) went to the health center, 14 (35 percent) sought help from relatives, 10 (25 percent) went to the hospital, 5 (12.5 percent) took their **children** to the doctor or a private clinic, 1 (1.5 percent) sought help at a pharmacy, and 2 (5 percent) went to a traditional healer. Six mothers requested advice or treatment from a health promoter when their child was ill.
26. When the 215 mothers surveyed were asked what symptoms would cause them to seek help for their child with a respiratory problem, 10 (4.7 percent) did not know any symptom, 62 (28 percent) knew at least **one** symptom, and 35 (17 percent) knew two symptoms. The frequency of the answers given by the 215 mothers surveyed with regard to the serious symptoms that would cause them to seek help if their child had a respiratory problem was as follows: 102 (49 percent) rapid breathing, 50 (24 percent) fever, 47 (22.6 percent) cough, 35 (16.8 percent) chest indrawing, 26 (12.5 percent) no appetite, and 16

(7.7 percent) others.

G. Immunization

27. Of the 215 children included in the survey, 214 (99.5 percent) were immunized at least one time according to their mothers. One mother indicated her child had never been immunized.
28. Of the 215 mothers interviewed, 190 (88.2 percent) knew that their children should receive vaccination against measles at 9 months of age, and 25 did not know when they should immunize their children against measles.
29. Asked the principal reason for which a pregnant woman should be vaccinated against tetanus, 157 (73.3 percent) answered that the TT vaccine works to protect the mother and her child. Twelve mothers (5.6 percent) indicated that the TT vaccine worked only to protect the mother, and 23 (10.7 percent) indicated that it served only to protect the infant. 23 (10.7 percent) mothers answered that they did not know what purpose the vaccine against tetanus had.
30. In asking the 215 mothers surveyed how many vaccinations against tetanus a pregnant woman should receive in order to protect the child, 1 (0.5 percent) answered one dose, 26 (12.1 percent) responded 2 doses, and 184 (85.6 percent) indicated more than 2 doses. Twelve mothers answered that they did not know how many doses they should receive in order to protect the child.
31. Of the 215 children involved in the survey, 196 (91.2 percent) had an immunization record, 16 (7.4 percent) had lost the immunization record, and 3 (1.4 percent) never had received an immunization record.
32. Based on the immunization record, the following chart shows the immunization coverage of children between 12-23 months. The baseline, Mid-Term and Final immunization coverage included. The children without an immunization record were included in the calculation of immunization coverage but were considered as if they had not been immunized.

Vaccination Coverage in Children 12-23 Months  
According to Types of Vaccination Doses  
August 1994

aqu: aqui

Vaccine	Baseline Percentage	Midterm Percentage	Final Percentage
BCG	28.1	55.8	97.8
Polio I	53.8	73.3	89.0
Polio II	45.2	67.4	79.1
Polio III	36.7	54.7	79.1
DPT I	51.4	66.3	97.8

DPT II	41.9	59.3	85.7
DPT III	32.9	53.5	84.6
Measles	42.9	66.3	85.7
Fully Immunized	19.5	44.2	84.6

Of the 91 children 12-23 months old, 77 (84.6 percent) were fully immunized (they received one dose of BCG, Polio I, Polio II, Polio III, DPT I, DPT II, DPT III, and measles vaccines).

#### H. Maternal Health

33. Of the 215 mothers surveyed, 105 (48.8 percent) had their prenatal care card, 52 (24.2 percent) had lost their cards, and 58 (27 percent) had never received a card.
34. Of the mothers who had their prenatal care card 6 (5.7 percent) had received one TT vaccination, and 51 (48 percent) had received two vaccinations.
35. Among the mothers that had their prenatal care card, 6 (6 percent) had one prenatal visit registered, and 100 (95.6 percent) had two prenatal visits registered.

#### I. Family Planning and Child Spacing

36. Of the 215 mothers surveyed, 20 (9.7 percent) were pregnant, 2 (1.0 percent) did not know if they were pregnant, and 194 (90.3 percent) were not pregnant.
37. Of the mothers who were not pregnant or who did not know if they were, when asked if they would like to have another child in the next two years, 147 (75.6 percent) answered no, 1 answered that they did not know, and 47 (24.1 percent) answered yes.
38. Of the mothers who did not want another child in the next two years or were not sure, 79 (52 percent) were using a contraceptive method, and 73 were not.
39. The chart below shows the methods used by the 83 women to avoid pregnancy.

#### Coverage of Men and Women Using Methods of Family Planning

Method	Mid-term	Final Evalucion-Percentage
Contraceptive Pills	51.4	58.4

Tubal Ligation or Vasectomy	38.6	28.2
IUD (Intrauterine Device)	2.9	5.5
Exclusive Breast-feeding	7.1	7.9
Total	100	100.0

40. Asked at how many months of pregnancy a woman should go to see a doctor, 194 (90.2 percent) answered that they should see a doctor during the first trimester of pregnancy, 29 (13.4 percent) said during the second trimester, and 15 (6.9 percent) answered that they did not know when they should see a doctor.

#### IV. DISCUSSION OF RESULTS (AND RECOMMENDATIONS)

##### A. Mother's Education

Education is one of the indicators of major importance for measuring the level of the quality of life of the population and the potential for promoting development. In the survey, 67 percent of the 215 mothers had reached some level of primary education, and 33 percent of this group had received secondary education. This shows that a potential exists for social promotion and for the design and implementation of an education program that responds to the objectives of the project.

##### **Recommendations**

Create an education program focused on popular education which integrates health interventions and development interventions.

##### B. Breast-feeding and Nutrition

The survey showed that 70.6 percent of the mothers were exclusively breast-feeding their child under 4 months of age by the end of the project. The rate of exclusive breast-feeding in the country is only 5 percent (Survey of Demographics and Health, 1993 PROFAMILIA, National Office of Planning, Dominican Republic).

The survey revealed two factors that facilitate the practice of breast-feeding. First, there was a high number (97 percent) of mothers that breast-fed at least once. Second, the survey indicated a high proportion of mothers (88 percent) that breast-fed for the first time during the first eight hours after giving birth. These two factors demonstrate that an opening exists for promoting breast-feeding and that we need to seek new strategies in order to facilitate the practice of exclusive breast-feeding until the fourth month.

On the other hand, some factors exist that impede the practice of exclusive breast-feeding until the fourth month. First, many popular beliefs exist that associate powdered milk with healthy and

strong children. These beliefs are sometimes initiated by the mass media and perpetuated by doctors who frequently prescribe powdered milk for children less than 4 months old. Other popular beliefs against mother's milk are maintained by grandmothers who believe that water or tea should be introduced very early in the life of the child in order to protect the child's fragile digestive system. Finally, many mothers are migrating in search of employment to the capital or emigrating to European countries, and leave their children from a very early age in the care of the grandmother.

The survey revealed that a high number of mothers are feeding their children sources of Vitamins C and A, protein, and carbohydrates. Still, it remains to be determined if the quality and frequency of these nutrients are appropriate.

### **Recommendations**

1. Create a series of trainings directed especially at grandmothers about the importance and benefits of exclusive breast-feeding during the first 4 months of an infant's life. This will motivate grandmothers to be promoters of exclusive breast-feeding in their communities.
2. Present the results of the survey to the MOH to encourage its representatives to train and motivate doctors on the importance of exclusive breast-feeding for the first 4 months.
3. Develop income-generating activities so that mothers do not have to migrate or emigrate in search of work.

### **C. Diarrheal Diseases**

One of the Final Project objectives for diarrheal diseases was that 70 percent of mothers would know how to prepare ORS and use it during diarrheal episodes in their children. The survey indicated that 89 percent of mothers knew how to correctly prepare the home-made ORS and 56 percent administered it to their child during diarrhea. Additionally, 66 percent of the mothers whose child had had an episode of diarrhea used some form of ORT, including ORS, rice water, and juices.

The fact that 14 percent of mothers whose child had had an episode of diarrhea administered antidiarrheal medicines or antibiotics indicates the urgent necessity of training doctors on how to manage diarrheal diseases.

The second Final project objective for diarrheal diseases was that 80 percent of mothers would continue to nurse their child during an episode of diarrhea. The survey revealed that 78.5 percent of the mothers whose child had diarrhea nursed at normal or more than normal levels during these episodes.

### **Recommendations**

1. Continue training mothers with regard to the management of diarrheal diseases.
2. Coordinate with the MOH training for doctors in the area on

the management of diarrheal diseases at the community level.

#### D. Acute Respiratory Infections

The Final project objective for AR1 was that 90 percent of mothers of children under the age of 5 years would know two or three symptoms of AR1 and know where to refer their child in case of pneumonia. The survey revealed that only 73 percent of mothers knew at least one symptom. Despite this finding, 80 percent of mothers sought help when their child showed symptoms of ARI. The fact that a third of the mothers sought help from relatives indicates that community training should involve not only the mothers but also the community as a whole.

One of the reasons why a very low number of mothers knew more than one symptom of pneumonia is that AR1 has been the most recently implemented intervention at the community level. More training will be held in the communities in the next few months.

AR1 has been the most common disease in the 15 communities surveyed. The prevalence of AR1 (67.5 percent) determined by the survey does not differ much from the data established during the baseline period (67.2 percent). There are many environmental factors which contribute to the high prevalence, such as the use of firewood for cooking and much dust.

#### **Recommendations**

1. Make community training in the area of AR1 a priority.
2. Involve the whole community in the training on ARI.
3. Work on the environmental challenges together with development promoters.

#### E. Immunization

The Final Project objective for EPI was that 85 percent of children from 12 to 23 months of age would be fully immunized. The survey revealed that 84.6 percent of the children in this age range were fully immunized.

#### **Recommendations**

1. Seek a dialogue with the mothers **of** the communities of the project in order to create a more effective strategy for the maintenance of record cards.
2. Coordinate with the **MOH** so that the immunization cards are given to the mother in the hospital or at the health center after the child has been immunized with the **BCG** vaccination.

#### F. Maternal Health

The objective of the project for maternal health was that 70 percent of pregnant women **would** have received TT2 before giving birth. Among the very small number (29.8 percent) of mothers who

had their record cards of immunization or prenatal control, the percentage with TT2 was 83.6 percent.

In the Funal survey, none of the mothers had their record card of immunization! consequently, the project has accomplished a significant increase in mothers with such cards. The registers of the health promoters indicate that 100 percent of the pregnant women in the communities of the project were immunized with TT2. Again, the challenges related to maintenance of the health records can be observed.

The majority of mothers knew that they should receive two or more doses of TT, but only a little more than half knew that it protects the mother as well as the child. This suggests that more time should be invested in the training of mothers so that they have a better comprehension of this mechanism that promotes their own health.

### **Recommendations**

1. Seek a dialogue with the MOH and mothers in order to create a more effective strategy for maintaining TT and prenatal checkup cards.
2. Coordinate with the rural clinics so that on the days for prenatal services, the health promoters can be present to review the prenatal control card and to emphasize the importance of the maintenance of the card.
3. Educate mothers with regard to the reasons why women should take care of their reproductive health.

### **G. Family Planning and Child Spacing**

The survey revealed that the rate of fertility in the area is 7.7 percent, nearly twice the national rate (3.5 percent). This reality is made more serious when it is taken into account that 50 percent of the mothers in the region are single.

The majority of the mothers that were not pregnant during the survey answered that they did not want another child in the next two years. But only half of these mothers were using any type of contraceptive method. The majority of the mothers who were using modern methods used contraceptive pills (51.4 percent), tubal ligation or vasectomy (38.6 percent), and IUD (2.9 percent).

The MOH provides the contraceptive pills and IUDs. Tubal ligations are provided by the state and have a minimum cost of RD\$50.00. The Catholic Church has not had a marked influence against the use of modern contraceptive methods. Mothers have knowledge of the modern contraceptive methods. The challenges related to the practice of family planning are associated with more complex problems such as the lack of control of a woman over her own sexuality and reproductive system.

### **Recommendations**

1. Promote educational programs regarding sexuality and

reproduction that involve women and men. The presence of **male** educators (such as development facilitators) is of great importance so that men in the communities will attend the trainings.

2. Involve doctors at the health centers in the education on sexuality and reproduction at the community level.
3. Develop educational programs on sexuality and reproduction with adolescents (boys and girls).

#### V. **SURVEY COSTS**

Following are the costs associated with the preparation, training, and conduct of the survey. Expenses related to the use of the survey trainer, who is part of the staff of WVRD, will be borne by WVRD and are not included below.

CONCEPT		AMOUNT US\$
A.	Personal	
	1. Consultancy	\$ 478.00
	2. 15 interviewers	<b>1,196.00</b>
	3. Training of supervisors and interviewers	360.00
	4. Accommodation	431.00
	5. Food	245.00
B.	Transportation	
	1. Fuel	111.00
	2. Taxi driver	84.00
C.	Office Supplies	<u>93.00</u>
TOTAL		<b>US\$2,998.00</b>

#### VI. **APPENDICES**

- A. English Questionnaire
- B. Spanish Questionnaire
- c. List of Communities, Populations, and Interviews
- D. Frequency Tables and Cross Tabulations

# SUPERVISRS AND INTERVIEWERS

1. **Maria** Luisa Aquino

Interviewrs

2. ~~C~~armen Vargas

"

3. Rosa Pelaez

"

4. Eugenia Martinez

"

5. Jose Michel

"

6. Julio Zapata

"

7. Mercedes Garcia

"

8. Pedro Encarnacion

"

9. **Berta** Rodriguez

"

10. Duarte Perez

"

11. **Juana** Polanco

"

12. Brigida Amparo

"

13. Ivelisse Vidal

"

14. Geronomi Garcia

"

15. Andres.Encarnacion

"

16. Julio Volquez

"

17. Nertha Castro

Supervisors

Andrea Gomez

"

Adela Vargas

"

BARAHONA CHILD SURVIVAL PROJECT FINAL REPORT

APPENDIX 2

Vision Mundial/Rep. Dominicana

CUESTIONARIO SOBRE CONOCIMIENTOS Y PRACTICAS EN SUPERVIVENCIA  
INFANTIL, BARAHONA, REP. DOMINICANA

[illegible]

- Nombre \_\_\_\_\_ Edad (años) \_\_\_\_\_

- Nombre \_\_\_\_\_

Fecha de nacimiento        /        /         
                                    día/ **mes**/ año

Educación/ocupación de la madre

3. Cual fue el último curso que aprobó ?

- |                      |       |
|----------------------|-------|
| 1. ninguno           | [ 1 ] |
| 2. primaria y no lee | [ ]   |
| 3. primaria y si lee | [ ]   |
| 4. secundaria o más  | [ ]   |

4. Realiza Ud. alguna actividad por la cual recibe dinero? (puede **marcar más** de una respuesta)

- a. no, ninguno [ ]
- b. vendiendo verduras o frutas [ ]
- c. **venta** de comidas o frituras [ ]
- d. empleada **doméstica/lavandera/otros** serv. [ ]
- e. tienda/pulperia/vendedor/ropa **usada** [ 3 ]
- f. trabajador asalariado [ ]
- g. otros (especifique) [ 3 ]

5. Quién cuida de (nombre del niño) mientras trabaja o está fuera de casa?  
(puede marcar más de una respuesta)
- a. el niño está/va con la mamá [    ]
  - b. el esposo/compañero [    ]
  - c. hermanos mayores [    ]
  - d. parientes/abuela [    ]
  - e. vecinos/amigos [    ]
  - f. lo deja sólo [ 3 ]
6. ¿Cuál es la enfermedad más común en su casa?
- 1. enfermedades respiratorias (tos) [    ]
  - 2. fiebre, convulsiones [    ]
  - 3. vómitos, diarrea [    ]
  - 4. femeninos (gineco-obstétricos) [    ]
  - 5. reumatismo (dolores articulares) [    ]
  - 6. otros (especifique) \_\_\_\_\_ [    ]

#### Lactancia materna/nutrición

7. Está dando de mamar a (nombre del niño)?
- 1. sí [    ] ---> PASE A LA 9
  - 2. no [ 3 ]
8. Le dió de mamar alguna vez a (nombre del niño)?
- 1. sí [    ]
  - 2. no [    ] ---> PASE A LA 10
9. Después del nacimiento, cuando pegó al pecho a (nombre del niño) por primera vez?
- 1. durante la primera hora después del parto [    ]
  - 2. durante las primeras 8 horas después del parto [    ]
  - 3. más de 8 horas después del parto [    ]
  - 4. no se acuerda [    ]
10. a. Le está dando agua o té a (nombre del niño)?
- 1. sí [ 3 ]
  - 2. no [    ]
  - 3. no sabe [ 3 ]
- b. Le está dando leche en polvo, o de vaca a (nombre del niño)?
- 1. sí [    ]
  - 2. no [    ]
  - 3. no sabe [    ]
- c. Le está dando alimentos blandos como avena, maicena o pures a (nombre del niño)?
- 1. sí [ 1 ]
  - 2. no [    ]
  - 3. no sabe [ 3 ]
- d. Le está dando jugos de frutas a (nombre del niño)?
- 1. sí [    ]
  - 2. no [ 3 ]
  - 3. no sabe [ 1 ]

- e. Le está dando naranjas, toronjas, piñas, cerezas, guayaba, a (nombre del niño) ?
1. si [ ]
  2. no [ 3 ]
  3. no sabe [ 3 ]
- f. Le está dando zanahorias, auyama, mangos, o lechosa a (nombre del niño)?
1. si [ 1 ]
  2. no [ ]
  3. no sabe [ 3 ]
- g. Le está dando vegetales verdes como vainitas, molondrón, hoja lechuga, o la hoja de zanahoria a (nombre del niño)?
1. si [ ]
  2. no [ ]
  3. no sabe [ 1 ]
- h. Le está dando carne o pescado a (nombre del niño)?
1. si [ ]
  2. no [ 3 ]
  3. no sabe [ 3 ]
- i. Le está dando habichuelas a (nombre del niño)?
1. si [ ]
  2. no [ 3 ]
  3. no sabe [ 1 ]

Le está dando huevos o queso a (nombre del niño)?

1. si [ 1 ]
2. no [ ]
3. no sabe [ ]

Le pone azúcar o miel a los alimentos de (nombre del niño)?

1. si [ ]
2. no [ 3 ]
3. no sabe [ 1 ]

Le pone aceite o mantequilla a los alimentos de (nombre del niño)?

1. si [ ]
2. no [ ]
3. no sabe [ 3 ]

11. ¿Qué puede hacer la madre durante los seis primeros meses para producir más leche? (puede marcar más de una respuesta).

- a. no sabe [ 1 ]
- b. dar de mamar inmediatamente después del parto (sin descartar el calostro) [ ]
- c. cuidar los pechos y pezones [ ]
- d. lactar frecuentemente para estimular la producción de leche [ 1 ]

- e. dar exclusivamente de lactar, durante los cuatro primeros meses [
- f. evitar el biberdn [ 3
- g. re-amamantar (la madre puede volver a la lactancia exclusiva si la habia dejado) [
- h. otros (especifique) \_\_\_\_\_ [ 3

### Enfermedades\_diarréicas

12. Ha tenido (nombre del niño) diarrea en las dos dltimas semanas?
  - 1. si [ ]
  - 2. no [ ] ----> PASE A LA 19
  - 3. no sabe [ 1 ----> PASE A LA 19
13. Durante la diarrea de (nombre del nifio), le dió de mamar ----> LEA LAS OPCIONES A LA MADRE
  - 1. **mas** ? [
  - 2. igual ? [ 3
  - 3. menos ? [
  - 4. le **quitó** el pecho ? [ 3
  - 5. ya lo habia destetado? [ ]
14. Durante la diarrea de (nombre del nifio), le dió otros liquidos (ademds de mamar)? ----> LEA LAS OPCIONES A LA MADRE.
  - 1. **más** ? [
  - 2. igual ? [ 3
  - 3. menos ? [
  - 4. no le **dió** llquidos ? [ 3
  - 5. solo le da de mamar [ 1
15. Durante la diarrea de (nombre del nifio), le dió alimentos solidos y semisolidos ----> LEA LAS OPCIONES A LA MADRE
  - 1. **más** ? [
  - 2. igual ? [ 3
  - 3. menos ? [ ]
  - 4. no le **dió** alimentos ? [ ]
  - 5. solo le da de mamar ? [ ]
16. Cuando (nombre del niio) tuvo diarrea, que tratamiento le dió ? (si es que usó alguno)  
(puede **marcar más** de una pregunta)
  - a. nada [
  - b. sobres de sales **orales** [ 3
  - c. **solución** de agua y sal (**suero casero**) [ ]
  - d. agua de arroz [ ]
  - e. cualquier **líquido** [
  - f. medicinas anti-diarreicas o **antibióticos** [ 3
  - g. otro (especifique) \_\_\_\_\_ [ 3
17. Cuando (nombre del niño) tuvo diarrea, **pidió** consejo ayuda?
  - 1. si [ ]
  - 2. no [ ] ----> PASE A LA 19

18. A **quién** pidió consejo o ayuda para la diarrea de (nombre del niño)?  
(puede marcar más de una respuesta)
- |                                     |   |   |
|-------------------------------------|---|---|
| a. hospital                         | [ |   |
| b. centro de salud/puesto de salud  | [ | 3 |
| c. <b>médico/clínica</b> particular | [ |   |
| d. farmacia                         | [ | 3 |
| e. promotor de salud                | [ |   |
| f. curandero                        | [ | 3 |
| g. partera                          | [ |   |
| h. parientes y amigos               | [ | 3 |
| i. otro (especifique) _____         | [ | 3 |
19. Que **señales** de gravedad harían que Ud. busque ayuda para la diarrea de (nombre del niño) ?  
(puede marcar más de una respuesta)
- |   |   |   |
|---|---|---|
| a. no sabe  | [ | 1 |
| b. vómitos  | [ |   |
| c. fiebre   | [ | 3 |
| d. sed, boca seca, ojos hundidos, mullera hundida, orina poco ( <b>deshidratación</b> ) | [ |   |
| e. diarrea prolongada (más de 14 días)  | [ | 3 |
| f. sangre en las heces  | [ |   |
| g. <b>pérdida</b> del apetito   | [ |   |
| h. <b>débil</b> o desganado   | [ |   |
| i. otros (especifique) _____  | [ | 3 |
20. Que debe hacer una madre cuando su niño tiene diarrea? (puede marcar más de una respuesta)
- |   |   |  |
|---|---|--|
| a. no sabe  | [ |  |
| b. iniciar con líquidos lo mas pronto posible   | [ |  |
| c. dar al <b>niño</b> mas líquidos de lo usual  | [ |  |
| d. dar alimentos con mas frecuencia y <b>menor</b> cantidad                                 | [ |  |
| e. preparar y administrar SRO correctamente   | [ |  |
| f. llevar al <b>niño</b> a un centro de salud   | [ |  |
| g. alimentar mas al niño <b>después</b> de la diarrea <b>de manera</b> que recupere el peso | [ |  |
| h. parar los líquidos   | [ |  |
| i. parar la <b>alimentación</b>   | [ |  |
| j. otros (especifique) _____  | [ |  |
21. **Cómo** se prepara la sales **orales** (**suero** de sobre) ?
- |                       |   |   |
|-----------------------|---|---|
| 1. Correcto           | [ |   |
| 2. Incorrecto/no sabe | [ | 3 |
22. **Qué** debe hacer una madre cuando su **niño** se está recuperando de la diarrea?  
(puede **marcar** mas de una respuesta)
- |   |   |   |
|---|---|---|
| a. no sabe  | [ | 1 |
| b. dar alimentos con mas frecuencia y <b>menor</b> cantidad | [ |   |
| c. mas alimentos de lo usual                                | [ | 3 |
| d. alimentos con alto contenido calórico                    | [ | 3 |
| e. otros (especifique) _____                                | [ | 3 |

### Infecciones\_Respiratorias\_Agudas

23. Ha estado (nombre del niño) enfermo con tos o resfriado en las dos últimas semanas?
1. si
  2. no [ 1 ----> PASE A LA 27
  3. no sabe [ ] ----> PASE A LA 27
24. Ha estado (nombre del niño) con respiración rápida, o respiraba como cansado (disnea) ?
1. si [ ]
  2. no [ ] ----> PASE A LA 27
  3. no sabe [ ] ----> PASE A LA 27
25. Buscó ayuda para (nombre del niño) cuando estuvo resfriado ?
1. si [ ]
  2. no [ 3 ----> PASE A LA 27
26. De quién recibió consejo o ayuda cuando (nombre del niño) cuando estuvo resfriado? (puede marcar más de una respuesta)
- |                                    |     |
|------------------------------------|-----|
| a. hospital                        | [ ] |
| b. centro de salud/puesto de salud | [ 3 |
| c. médico/clínica particular       | [ 3 |
| d. farmacia                        | [ ] |
| e. promotor de salud               | [ ] |
| f. curandero                       | [ ] |
| g. partera                         | [ 3 |
| h. parientes y amigos              | [ ] |
| i. otro (especifique) _____        | [ 3 |
27. Cuáles son las señales de gravedad que le harían buscar ayuda si (nombre del niño) estuviera resfriado? (puede marcar más de una respuesta)
- |                                 |     |
|---------------------------------|-----|
| a. no sabe                      | [ ] |
| b. respiración rápida y agitada | [ 3 |
| c. se le hunde el pecho         | [ ] |
| d. pérdida del apetito          | [ 3 |
| e. fiebre                       | [ ] |
| f. tos                          | [ 3 |
| g. otro (especifique) _____     | [ 3 |

### Inmunizaciones

28. Ha sido vacunado alguna vez (nombre del niño)?
1. si [ ]
  2. no [ ]
  3. no sabe [ ]
29. A qué edad (nombre del niño) debería recibir la vacuna contra el sarampión?
1. especifique en meses [-----]
  2. no sabe [ ]

30. Cual es la razón principal por la que una mujer embarazada debe vacunarse contra el tétanos ?
1. para proteger madre y niño contra el tétanos [ 1
  2. para proteger solo a la mujer contra el tétanos [ 3
  3. para proteger solo al niño contra el tétanos [
  4. otros o no sabe [ 3
31. Cuántas vacunas contra el tétanos debe recibir una mujer embarazada, para proteger al niño ?
1. una [
  2. dos [ 3
  3. más de dos [
  4. ninguna [ 3
  5. no sabe [ 1
32. Tiene Ud. la tarjeta de vacunación de (nombre del niño) ?
1. si [ 1 (pida que se lo muestre!)
  2. **perdió** la tarjeta [ ]----> PASE A LA 34
  3. no, nunca tuvo [ 1----> PASE A LA 34

33. Mire la tarjeta de vacunación y registre las fechas de las inmunizaciones (día/mes/año) en el espacio correspondiente:

	PRIMERA	SEGUNDA	TERCERA
POLIO	___/___/___ -	___/___/___ -	___/___/___ -
DPT	___/___/___ -	___/___/___	___/___/___ -
SARAMPION	___/___/___		
BCG	___/___/___ -		

## Salud materna

34. Tiene Ud. su tarjeta de control prenatal ?  
 1. si [ ] (pida que se lo muestre!)  
 2. **perdió el carnet** [ ----> PASE A LA 37  
 3. no [ 3 ----> PASE A LA 37

35. ☐ Mire la tarjeta control prenatal y registre el número de vacunas TT en el espacio correspondiente:
- |              |   |   |   |
|--------------|---|---|---|
| 1. una       | [ |   | ] |
| 2. dos o más | [ | 3 | ] |
| 3. ninguna   | [ | 3 | ] |
36. ☐ Mire el tarjeta de control prenatal y registre cuantos controles pre-natales tuvo la madre:
- |              |   |   |   |
|--------------|---|---|---|
| 1. uno       | [ |   | ] |
| 2. dos o más | [ | 3 | ] |
| 3. ninguno   | [ | 3 | ] |

#### Planificación familiar y espaciamiento del embarazo

37. Está Ud. ahora embarazada?
- |            |   |  |   |                    |
|------------|---|--|---|--------------------|
| 1. si      | [ |  | ] | ----> PASE A LA 41 |
| 2. no      | [ |  | ] |                    |
| 3. no sabe | [ |  | ] |                    |
38. Quisiera Ud. tener otro hijo en 10s prdximos dos aios?
- |            |   |   |   |                    |
|------------|---|---|---|--------------------|
| 1. si      | [ |   | ] | ----> PASE A LA 41 |
| 2. no      | [ | 3 | ] |                    |
| 3. no sabe | [ | 3 | ] |                    |
39. Está Ud. usando algún método para no embarazarse o retrasar el prdximo embarazo?
- |       |   |   |   |                    |
|-------|---|---|---|--------------------|
| 1. si | [ | 1 | ] |                    |
| 2. no | [ | 1 | ] | ----> PASE A LA 41 |
40. Cual es el metodo principal que Ud. o su marido están usando ahora para no embarazarse?
- |                                   |   |  |   |
|-----------------------------------|---|--|---|
| 1. ligadura de trompas/vasectomfa | [ |  | ] |
| 2. inyecciones                    | [ |  | ] |
| 3. pastillas anticonceptivas      | [ |  | ] |
| 4. dispositivo intra-uterino      | [ |  | ] |
| 5. diafragma                      | [ |  | ] |
| 6. condones                       | [ |  | ] |
| 7. espumas o gel                  | [ |  | ] |
| 8. lactancia materna exclusiva    | [ |  | ] |
| 9. metodo del ritmo               | [ |  | ] |
| 10. abstinencia                   | [ |  | ] |
| 11. coito interrumpido            | [ |  | ] |
| 12. otros (especifique) _____     | [ |  | ] |

41. A los cuantos meses de embarazo una mujer debe ir a ver algún médico?

- |                                       |   |   |
|---------------------------------------|---|---|
| 1. al primer trimestre, 1-3 meses     | [ |   |
| 2. a la mitad del embarazo, 4-6 meses | [ | 3 |
| 3. al último trimestre, 7-9 meses     | [ | ] |
| 4. no necesita ir                     | [ | ] |
| 5. no sabe                            | [ | 1 |

BARAHONA CHILD SURVIVAL PROJECT FINAL REPORT

APPENDIX 3

**Appendix 3: TABLE 1**

No.	Indicator (Submit results only for indicators that reflect project interventions)	Results Numerator (N) Denominator (D) Percent (P)
01	NUT: Initiation of Breastfeeding-Percent of infants/children (less than 24 months old) who were breastfed within the first eight hours after birth.	N = 193 P = 89 D = 215
02	NUT: Exclusive Breastfeeding-Percent of infants under four months who are being given only breast milk.	N = 24 P = 70.6 D = 34
03	NUT: Introduction of Foods-Percent of infants age 5-9 months who are being given solid or semi-solid foods.	N = 33 P = 80.5
04	NUT: Persistence of Breastfeeding-Percent of children 20-24 months old who are still breastfeeding (and being given solid/semi-solid foods).	N = 0 P = 0 D = 16
05	CCD: Continued Breastfeeding-Percent of infants/children (less than 24 months old) with diarrhea in the past two weeks who were given the same amount or more food.	N = 30 P = 60 D = 50
06	CCD: Continued Fluids-Percent of infants/children (less than 24 months old) with diarrhea in the past two weeks who were given the same amount or more food.	N = 38 P = 86 D = 45
07	CCD: Continued Foods-Percent of infants/children (less than 24 months old) with diarrhea in the past two weeks who were given the same amount of food or more.	N = 27 P = 76 D = 50
08	CCD: ORT Usage-Percent of infants/children (less than 24 months old) with diarrhea in the past two weeks who were treated with ORT.	N = 33 P = 66 D = 50
09	Pneumonia Control: Medical Treatment-Percent of mothers who sought medical treatment for infant/child (less than 24 months old) with cough and rapid, difficult breathing in the past two weeks.	N = 28 P = 70 D = 40
10	EPI: Access-Percent of children age 12-23 months who received DPT1.	N = 77 P = 95.3 D = 81
11	EPI: Coverage-Percent of children age 12-23 months who received OPV3.	N = 73 P = 90 D = 81
12	EPI: Measles Coverage-Percent of children age 12-23 months who receive Measles vaccine.	N = 68 P = 83.9 D = 81
13	EPI: Drop-Out Rate-Percent of change between DPT1 and DPT3 doses [(DPT1-DPT3)/DPT1] for children age 12-23 months.	N = 3 P = 4.1 D = 74

No.	Indicator (Submit results only for indicators that reflect project interventions)	Results Numerator (N) Denominator (D) Percent (PJ)
14	MC: Maternal Card-Percent of mothers with a maternal card.	N = 105 P = 48.8 D = 215
15	MC.: Tetanus Toxoid Coverage (Card)-Percent of mothers who received two doses of tetanus toxoid vaccine (card).	N = 99 P = 94.3 D = 105
16	MC: Antenatal Visits (Card)-Percent of mothers who had at least one antenatal visit prior to the birth of the child (card).	N = 105 P = 100 D = 105
17	MC: Modern Contraceptive Usage-Percent of mothers who desire no more children in the next two years, or are not sure, who are using a modern contraceptive method.	N = 80 P = 54.4 D = 147

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APPENDIX 4

APPENDIX 4  
Program of Evaluation Activities  
September 12-23, 1994

**September 11:** Arrival of Dr. Jose Giron

**September 12:**

8:30 a.m. Meeting with Dr. Amiro Perez-Mera, Dominican Consultant, and Dr. Jose Angel Giron, External Consultant.

10:30 Meeting with Cesar Lopez, World Vision Field Office Director

11:30 Meeting with Claudio Done, Field Office Finance Director

2:30 p.m. Meeting with Santiago Rodriguez, Director of Operations

**September 13:**

7:00 a.m. Travel to Barahona

11:00 Meeting with Field Health Team

2:30 p.m. Visit with Development Committee, health promoters, and mothers in Jaquimeyes and La Hoya

**September 14:**

8:30 a.m. Meeting with Dr. Manolo **Feliz** and Dr. Victor Ventura from Regional Ministry of Public Health

10:30 Visit with leaders and mothers in Fundacion Community

2:30 p.m. Visit with leaders and mothers in Batoruco Community

**September 15:**

8:30 a.m. Meeting with evaluation team to review results and recommendations

2:30 p.m. Return to Santo Domingo

**September 16:**

8:30 a.m. Meeting with management staff from Santo Domingo to review results and recommendations

2:30 p.m. Work on writing report